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NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

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STATE OF NEW JERSEY
DEP'T OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF AN INQUIRY INTO THE PROFESSIONAL PRACTICE OF EUGENE C. FRENCH, M.D. LICENSE NO. 25MA05843600 PRACTICING MEDICINE AND SURGERY IN THE STATE OF NEW JERSEY	ADMINISTRATIVE ACTION ORDER OF REPRIMAND

This matter was presented to the State Board of Medical Examiners by Joan D. Gelber, Senior Deputy Attorney General, on inquiry into the professional practice of Eugene C. French, M.D.

Respondent Dr. French has been licensed to practice medicine during all times pertinent herein. His current practice is in internal medicine and infectious disease, at "ID Careguard," at 255 West Spring Valley Avenue, Suite 200, Maywood, NJ 07607.

By Board letter May 23, 2014, Dr. French was directed to appear because he had failed to respond to two previous Board letters requesting his treatment records of a named former patient and Dr. French's response to the patient's complaint. No response and no treatment records had been submitted.

The complaint was from a patient (who will be referenced herein as "Mr. A"), who had sought an initial visit with Dr. French

in early 2013. In preparation therefor, the patient submitted extensive prior treatment records of his already diagnosed serious infectious disease. His last blood test had been in September 2012. After two appointment cancellations by Dr. French's office, the patient's first visit was on June 4, 2013.

As reported by the patient, after a lengthy wait without explanation, Dr. French entered the examining room. Mr. A noted that Dr. French brought no medical records into the room. The patient recalled the visit as lasting "5 minutes" with no history requested, no examination, and little communication except that Dr. French said he would order blood work. The patient states that, when leaving the office, he was told by staff that Dr. French would call him with the results "either way."

After two weeks with no call, Mr. A called the office. He was told by staff that the lab report had been received. Mr. A called again another day, and was told by staff that the results "look good" and to repeat in four months. The patient complains that staff denied his request to speak with the doctor. Mr. A then asked to have the lab results mailed to him. He states that Dr. French then took the phone demanding to know why Mr. A was not going to come back as a patient, and then hung up on him. Mr. A reports that he ultimately received a one-page lab report, which he brought to his new treating doctor.

Upon being summoned to appear before the Board Committee, Dr. French finally produced his Curriculum Vitae[1] as requested by the Board, and his patient chart for Mr. A. It appears that Dr. French had not preserved either of the prior Medical Board letters.

Dr. French, who elected to represent himself, was questioned by the Committee about his chart. His record for the first (and

[1] Dr. French thereafter updated his CV to correctly reflect his current office address and the current status of his Board certification in Internal Medicine, which has lapsed.

only) visit of Mr. A has a form containing a mostly typical consent paragraph, authorizing release to Dr. French of information from any source necessary in the coordination of the patient's health care or for processing an insurance claim. In the midst of the standard language, however, is a sentence consenting to test results to be left on the patient's home answering machine or cellphone. On a separate page is a "Notice of Privacy Practices Acknowledgment", which provides a place for the patient to identify any persons to whom personal health care information can be released. The patient completed that separate page, listing no other person as authorized to receive Mr. A's protected health information.

Other intake pages, completed (according to Dr. French, by his staff) but unsigned, list past surgical history and a past medical history of + HIV, increased weight gain, hearing loss, thrombocytopenia, vascular necrosis, allergy status and medications. Lines for immunizations and dates are blank. A family history has potentially significant information ("heavy drinkers").

The Physical Examination page for this June 4, 2013 initial office visit for a new patient contains vital signs and simple history, which Dr. French said was completed by his RN nurse: Patient height 6'2", weight 348 lbs, normal vital signs. Further noted was receipt of Montefiore Hospital records; +HIV since 1999; last blood draw 09/2012. Last seen [by a doctor] 9/2012. Last ppd 2-3 years ago. No pneumo vaccine.

Dr. French's examination page has three columns for Clinical Evaluation, with checkmarks in the "NL" [normal] column, no checkmarks in the "Abnl" [abnormal] column, and no checkmarks in the "NE" (Not Examined) column. There are a few checks in the "NL" column: head including thyroid and scalp, mouth/throat, tympanic membrane, lungs/chest, vascular system-varicosities, upper and

lower extremities and spine/other musculoskeletal, none with any narrative and none consistent with the patient's recollection.

But despite this new patient's medical history and diagnosis, there is NO examination mark on this initial visit for entries specifically denominated on Dr. French's chart for the nose, sinuses, ears, eyes, ocular motility, anus and rectum, abdomen including hernia, external genitalia, feet, skin/lymphatics, neurological or psychiatric status. There is no mark for any heart sounds, no notation by Dr. French on any of the other pre-printed headings, or regarding the potentially significant family history.

Dr. French's handwritten notations are limited to "Not satisfied with HIV MD" [*i.e.*, the prior MD at Montefiore] and Stable 279.10 [dx immunodeficiency], exogenous obesity. Plan: [To do] Bloodwork [and, in the autumn, to do] Pneumo vaccine. RTO: 4 months. Several tests are marked on a lab requisition form. Added to the chart was a LabCorp report of 4 pages plus a page for serial monitoring report. A handwritten but undated notation by Dr. French says "All OK Repeat 4 mo." Another handwritten note says "F/U apt 10/4/13."

Dr. French testified that he is a solo practitioner and hastens daily from morning hospital rounds to his office, and sometimes back again to the hospital, and he is occasionally very late for office appointments. He asserted that he always apologizes to the patient when this happens. He acknowledged that he might not have had Mr. A's Montefiore Hospital records with him during their new patient encounter and might have been carrying only a clipboard, but he insisted that he would have seen the records. He acknowledged that his exam notes are scanty, but said that he might have done an examination of a body part without recording it. He emphatically denied that he asked no questions of Mr. A and performed no examination. However, he admitted that patients are

examined fully clothed in street garb with shoes. Asked how a Karposi's sarcoma would be discovered, or how he checked for "vascular system/varicosities" (checked as NL on the chart); he said he could tell by lifting the patient's trouser leg.

Dr. French was questioned regarding the propriety of placing a patient consent-to-receipt of test results on the patient's telephone or cellphone, printed in the middle of otherwise typical consent language for protection of medical fees. The Committee noted that for a physician treating infectious diseases, leaving test results even on a correctly dialed phone number, may unwittingly expose significant personal health information for someone other than the patient who happens to answer the phone. A telephone call inadvertently dialed to a wrong number, stating test results (such as HIV status) for the named recipient, would be a further serious breach of patient confidentiality.

In this case, a staff member had written on page 1 (of 4) of Mr. A's lab test results the following: 6/17/13-LMOM@home #. Dr. French acknowledged that this means that staff "left message on machine at home number." This - despite the patient's decision to not list any other persons to receive his personal information. Dr. French sought to justify this by saying he expected his staff's message to be limited to, *e.g.*, "Your lab results are ready." Another note on the lab result, after Mr. A's second call to the office, says "6/27/13 mailed to pt." Dr. French did not deny that two weeks had gone by without communicating the patient's lab test results. Dr. French said he had agreed to speak with the patient at Mr. A's second call, but the doctor terminated the call when the patient expressed displeasure at the service he had received.

Dr. French did not deny his failure to respond to two Board letters. He apologized, and ascribed this, and the patient complaint, to being overwhelmed by the duties he had undertaken,

and because he had moved his office, and because his staff had been unable to find the requested record - until a year later - after the Board's latest letter notified him to appear. As for his charting, Dr. French said he hoped to improve this when he starts using electronic medical records, and that he will use a scribe to take his dictation.

The Board has several concerns about this matter. Board rule N.J.A.C. 13:45C-1 *et seq.* requires a licensee to cooperate in a Board investigation by, in part, timely providing requested information and records. N.J.A.C. 13:35-6.5 requires preparation of patient records which accurately reflect the treatment or services rendered, and also requires prompt response to a patient's request, and to a Board request for production of the record. Although the Board twice provided ample time for Dr. French to respond, he failed to do so.

The Board also finds that, notwithstanding the patient's recollection, Dr. French probably did perform some level of questioning and examination, however brief and extremely limited, of Mr. A. However, the charted exam notes are significantly incomplete and inadequate for an initial visit of a new patient, particularly one with this patient's medical history, diagnosis and family history. The Committee notes that introduction of an EMR system will not substitute for the obtaining and documentation of actual information.

In addition, Dr. French's placement of the consent-to-receipt of test results by a message left on a phone/cellphone is highly questionable, especially for a physician promoting an infectious disease practice. That sentence should be moved to the Patient Privacy Acknowledgment page, and clearly marked. If the patient lists no other persons as authorized to receive the patient's personal health information (HPI) under HIPAA law (the Health

Insurance Portability and Accountability Act), the office should clearly ascertain whether the patient will risk the leaving of a phone message.

The Board encourages Dr. French to seek recertification in Internal Medicine, and to seek certification in Infectious Disease.

Taking all into account, however, the Board has determined that the within disposition is adequately protective of the public health, safety and welfare.

For sufficient cause shown,

IT IS, ON THIS DAY OF 2014

ORDERED that

1. Dr. French is reprimanded, pursuant to N.J.S.A. 45:1-21(h), for failure to comply with Board rules, more specifically, his initial and repeated failure to cooperate in the Board's investigation, N.J.A.C. 13:45C-1 et seq., and for his failure to document adequate Evaluation & Management notes for an initial examination of a new patient - particularly one with a serious disease - and to take reasonable measures to provide lab results and to protect patient confidentiality, N.J.A.C. 13:35-6.5;

2. Respondent shall cease and desist from the conduct of concern, and shall implement measures to assure compliance with Board rules; and

3. Within six months of the entry of this Order, Dr. French shall submit proof of having taken and successfully completed a Board-approved course in medical recordkeeping and received an unconditional passing grade.[2]

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[2] A list of Board-approved courses is available from the Board office. Such courses include but are not limited to, those offered by the Center for Personalized Education for Physicians http://www.cpepdoc.org/programs-courses/probe.

THIS ORDER IS EFFECTIVE UPON ENTRY.

STATE BOARD OF MEDICAL EXAMINERS

By: _____
STEWART A. BERKOWITZ, M.D.
President

I have read and understood the within Order and I agree to comply with its terms.

_____
Eugene G. French, M.D.

Witness:

_____

_____ 9/24/14
Exp 3/1/17

NOTICE OF REPORTING PRACTICES OF BOARD REGARDING DISCIPLINARY ACTIONS

Pursuant to N.J.S.A. 52:14B-3(3), all orders of the New Jersey State Board of Medical Examiners are available for public inspection. Should any inquiry be made concerning the status of a licensee, the inquirer will be informed of the existence of the order and a copy will be provided if requested. All evidentiary hearings, proceedings on motions or other applications which are conducted as public hearings and the record, including the transcript and documents marked in evidence, are available for public inspection, upon request.

Pursuant to 45 CFR Subtitle A 60.8, the Board is obligated to report to the National Practitioners Data Bank any action relating to a physician which is based on reasons relating to professional competence or professional conduct: (1) Which revokes or suspends (or otherwise restricts) a license;
(2) Which censures, reprimands or places on probation; (3) Under which a license is surrendered.

Pursuant to 45 CFR Section 61.7, the Board is obligated to report to the Healthcare Integrity and Protection (HIP) Data Bank, any formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation or any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such federal or State agency that is publicly available information.

Pursuant to N.J.S.A.45:9-19.13, if the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, it is obligated to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders are provided to that organization on a monthly basis. Within the month following entry of an order, a summary of the order will appear on the public agenda for the next monthly Board meeting and is forwarded to those members of the public requesting a copy. In addition, the same summary will appear in the minutes of that Board meeting, which are also made available to those requesting a copy. Within the month following entry of an order, a summary of the order will appear in a Monthly Disciplinary Action Listing which is made available to those members of the public requesting a copy. On a periodic basis the Board disseminates to its licensees a newsletter which includes a brief description of all of the orders entered by the Board. From time to time, the Press Office of the Division of Consumer Affairs may issue releases including the summaries of the content of public orders.

Nothing herein is intended in any way to limit the Board, the Division or the Attorney General from disclosing any public document.